HEALTH CARE AND WELFARE

Overview

During the past four years, Florida's health care and welfare delivery systems have undergone tremendous change. The Florida Legislature has been at the forefront in providing access to health care for Florida families, protecting health care consumers and elders, and promoting personal responsibility for welfare recipients.

As more Floridians receive health care through managed care organizations, the need for ensuring quality and containing costs has also increased. Concerns have arisen regarding the adequacy of consumer protections and whether consumers are even fully aware of existing protections they have regarding the care they receive. The Florida Legislature has responded to this challenge by strengthening and publicizing health care consumer protection laws. Existing patient protections, including the right to a second medical opinion, the right to emergency care, and the right to have licensed physicians make treatment denial decisions, are now clearly delineated in one statutory section to increase public awareness of protections available in other sections of law.

The Legislature has created several important initiatives to provide access to health care for families and children, including Medicaid and Florida Kidcare. Medicaid is a federally and state funded medical assistance program that pays for health care for the poor and disabled. The state budget for the Medicaid program for the current fiscal year is over $8.3 billion, and the program anticipates serving more than 1.6 million clients. Given the size of the Medicaid budget and the percentage of the state budget that Medicaid represents, the Legislature has been forced, over the past several years, to pursue fairly substantial Medicaid cost containment initiatives that have primarily focused on three fronts: disease management; fraud and abuse; and prescribed drugs. These and other initiatives have resulted in a total of over $1 billion in projected Medicaid budget reductions.

In 1998, the Legislature created the Florida Kidcare program, Florida's Title XXI child health insurance program, designed to make affordable health care coverage available for low-income uninsured children. Florida Kidcare currently consists of four components: Medicaid for children, the MediKids program, Healthy Kids, and the Children's Medical Services (CMS) Network.

As Florida's elderly population continues to grow, the demand for services increases. The impact of the needs of the elderly and disabled on the Medicaid budget is particularly significant. While the elderly and disabled represent about 20 percent of the Medicaid population, they account for almost 80 percent of the Medicaid budget. In addition to a focus on controlling the growth and utilization of nursing homes, the Legislature has addressed quality of care issues in nursing homes, including the strengthening of early warning systems, staffing ratios and inspection standards.

Any discussion of Florida's health care delivery system must certainly include reference to recent actions involving tobacco use and related litigation. Florida entered into a settlement

agreement with tobacco companies in 1997 that is expected to result in more than $11 billion to the State over a 25-year period. The Legislature subsequently created a Tobacco Endowment Fund to serve as a recurring source of revenue for Florida's children and elderly and for research into tobacco-related diseases.

Finally, in addition to ensuring healthier Floridians, the Legislature has actively sought to make Floridians more productive and self-sufficient. Florida became the first state in the nation to implement far-reaching welfare reform when it created the Work and Gain Economic Self-sufficiency (WAGES) Program in 1996. Through WAGES, Florida used flexibility provided by the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to place lifetime limits on cash assistance, provide job training, and require families to work. Florida has used funds saved from the Temporary Assistance for Needy Families (TANF) federal block grant that replaced federal Aid to Families with Dependent Children (AFDC) to provide childcare and other support to enable families to become self-sufficient. Since 1996, the monthly number of families receiving cash assistance has dropped 67 percent from 200,292 to 64,829. To continue to improve support for Florida families, the 2000 Legislature reorganized federal and state job training, employment, and welfare transition programs in a new Agency for Workforce Innovation under the leadership of a public-private board, Workforce Florida, Inc.

MANAGED CARE

Introduction

Dramatically increasing health care costs have paved the way in Florida for significant health care reforms and placed managed health care arrangements at center stage in efforts to restructure the health care delivery system. Florida has been on the cutting edge in developing various forms of managed care arrangements and continues to experiment with different options as managed care evolves.

Summary of Legislative Action Taken

The Legislature has acted numerous times to reform the business practices of managed care entities. Specific reform initiatives addressed in the 1999 legislative session include: providing patients greater choice in the selection of physicians and other health care providers; establishing mechanisms to ensure patients a remedy, legal or otherwise, when needed medical care is denied by their health plan; ensuring due process for providers terminated from a managed care panel; and refining health insurance laws to ensure available and affordable coverage.

Reacting to the public outcry about managed care's failure to cover "necessary" health care services, the Legislature has recently mandated that certain procedures be covered. Recent mandates include benefits relating to breast cancer, maternity care length of stay, and bone marrow transplants. Because each new mandated benefit increases the cost of an insurance or HMO policy, the Legislature continues to proceed very cautiously in requiring any new mandated benefits for insurance plans – carefully weighing the need for each mandated benefit against the potential for increased costs.

Most recently in the 2000 Session, the Legislature passed the Patient Protection Act of 2000 (chapter 2000-256, Laws of Florida), a comprehensive bill that builds on the successes Florida has realized in the health care arena and addresses a number of issues in order to guarantee existing patient protections, ensure quality of health care, and improve affordability and availability of health care. As part of the act, the Legislature has required that consumers and providers be notified of managed care entities' policies and procedures for the handling of grievances against the managed care entity and that the managed care entity provide the patient and provider with information about treatment denials in an expedient manner. In addition, the act requires that managed care organizations only allow doctors to make treatment denial decisions and that the patient and treating physician have an opportunity to appeal such decision in a timely manner.

Implementation

Managed care entities have continued to be a source of public concern since their creation in 1972. Despite the best efforts of legislators to take advantage of the benefits of increased efficiencies and cost savings, concerns about quality, choice, and the impact on total health continue to be widely voiced.

Due to the nature of managed care and its focus on cutting costs, there has been ongoing friction between managed care entities and their contract providers, such as physicians and hospitals, as well as between the managed care entities and their subscribers (patients). This has led to many changes to the law over the last 28 years, including provisions mandating that managed care entities provide certain services deemed by the public and the Legislature to be medically necessary health care services. Managed care entities oppose mandates on the basis that they cut into profits and result in increased premiums. In the 2000 Session, the Legislature determined that a more systematic approach should be used to balance the needs and desires of the public and providers with the costs to the patient and to employers who purchase health insurance for their employees. The legislation enacted provides for an assessment of the impact, including costs and benefits, of mandated health coverages.

Results and Impact

One of the most dramatic changes resulting from the advent of managed care is the manner in which providers and reimbursers interact. The relationship between managed care plans and providers is now largely a contractual one. Physicians who contract with managed care entities are concerned that their ability to pursue their profession and their livelihood is being compromised by the power managed care plans have to hire and fire physicians. Physicians want assurances that their professional judgment will not be impaired in their quest to provide the very best care for their patients. On the other hand, managed care plans want the latitude to ensure that quality of care is provided in the most cost efficient manner possible.

The impact of managed care legislation is a source of constant debate. Some critics have called for the complete dismantling of managed care in Florida. Others insist that managed care is the only way to handle what some perceive as a health care crisis. While the concept of managed care has been generally supported as a means of increased efficiency and cost reduction, there is

a heightened awareness on the part of consumers and legislators that improved efficiencies must not be achieved at the expense of quality.

THE FLORIDA KIDCARE PROGRAM

Introduction

In 1996, only 66 percent of U.S. children younger than 18 (47 million) were covered by private health insurance, while 10.6 million children (14.8%) were uninsured, living generally in lower-income working families. Florida had one of the nation's largest uninsured populations. Nearly 23 percent of those below the age of 65 were uninsured. At that time, of Florida's 2.8 million uninsured non-elderly residents, approximately one-third were children. Despite eligibility expansions in the Medicaid program and an increase in enrollment in the Florida Healthy Kids Program, more than 823,000 of Florida's 3 million children remained uninsured. Of this number, an estimated 293,885 lived in families that were potentially Medicaid eligible due to family income below 100 percent of the federal poverty level; 259,336 lived in families with income between 101 and 200 percent of the federal poverty level; and 270,246 lived in families with income in excess of 200 percent of the federal poverty level.

In an effort to provide a mechanism for states to make affordable health care coverage available for low-income uninsured children, Congress passed the federal Balanced Budget Act of 1997 (P.L. 105-33), which created Title XXI of the Social Security Act and allocated funds to states for the purpose of providing health insurance to uninsured children who live in low-income families.

Summary of Legislative Action Taken

Chapter 98-288, Laws of Florida, created the Florida Kidcare program, Florida's Title XXI child health insurance program. Florida Kidcare consists of five components: Medicaid for children; the MediKids program; Healthy Kids; the Children's Medical Services (CMS) Network; and employer-sponsored dependent (ESD) coverage. (Florida's Kidcare ESD coverage proposal has been denied by the federal Health Care Financing Administration, according to a November 5, 1999 letter from HCFA.)

Chapter 2000-253, Laws of Florida, provides improvements to the existing Florida Kidcare Program. The new law: adds certain elements to Kidcare reporting requirements; requires a monthly enrollment report; includes Kidcare in the revenue estimating process; modifies eligibility review processes; accelerates Kidcare enrollment; directs that a more simple eligibility redetermination process be developed; clarifies the Children's Medical Services (CMS) screening and referral process; ensures smooth transition across program components; adds a dental benefit for the Kidcare program, subject to a specific appropriation; and specifies a study of the feasibility of subsidizing health insurance coverage for children of certain state employees.

Implementation

Medicaid, MediKids, and the CMS Network are administered by state agencies. The three programs, which include dental coverage, offer the Medicaid benefit package for children. Medicaid and MediKids are administered by the Agency for Health Care Administration. The CMS Network, a division of the Department of Health, serves children with special health care needs - those with serious or chronic physical or developmental conditions who require extensive preventive and maintenance care. The CMS Network is a system of managed care with multi-disciplinary, regional, and tertiary pediatric care providers who offer prevention and early intervention services, primary care and specialty care, as well as long-term care for medically complex, fragile children. A sub-component, the Behavioral Health Specialty Care Network, provides behavioral health care services for children with severe mental health problems.

The Healthy Kids Program is administered by the nonprofit Florida Healthy Kids Corporation created under s. 624.91, F.S. The program began in the early 1990s and offers a benefit package through commercially licensed insurers, which differs from the Medicaid benefit package for children. As created, it does not include dental coverage (except for cleanings and x-rays, provided at local option) and certain other services that are included in the Medicaid benefit package. The Healthy Kids Program is the largest non-entitlement program under the Florida Kidcare program. It was authorized to offer a certain number of enrollment slots to each county without requiring local matching funds (currently established at 500 slots per county). If a county wants to offer more enrollment slots, a local match is required. Currently, the program is operational in all but three counties, where provider networks are currently under review.

As Kidcare partners, each department, agency, and program involved in the Kidcare Program has specified duties and responsibilities. The Agency for Health Care Administration administers the Medicaid and MediKids programs and processes premium payments for the Florida Healthy Kids and CMS programs. The Department of Children and Family Services is responsible for developing a simplified application process and determining eligibility for the Florida Kidcare program. The original Kidcare law provided the opportunity to use a third party administrator for the purposes of determining eligibility for the Kidcare program. The Department of Health administers the CMS Network and is responsible for outreach and the Kidcare Coordinating Council. The Florida Healthy Kids Corporation administers the Healthy Kids Program and contracts with the Agency for Health Care Administration to provide a third party administrator for the purposes of premium collection and eligibility screening/processing. The Department of Insurance is responsible for certifying qualified health plans and is designated to be responsible for the administration of the ESD coverage.

Results and Impact

As of July 1, 2000, Title XXI-funded Kidcare enrollment by program component was as follows:

Healthy Kids	120,686
MediKids	19,330
CMS Network	4,989
Medicaid for teens	17,487
TOTAL	162,674

This represents a significant increase in enrollment since the inception of the program.

The FY 2000-2001 General Appropriations Act funds 102,000 new slots for Kidcare coverage, for a total of 309,482 children. This represents an increase of $96 million in the state's obligation to insure children. Proviso language caps the Healthy Kids local match at $14,448,850, which will save counties an estimated $8.6 million. The Florida Healthy Kids Corporation is directed to review current local match requirements and develop a recommendation for a multi-year proposal related to the reduction of local match, with a report by November 1, 2000. A cap of $13.5 million is imposed for state-only funding for children not eligible for Title XXI funding.

MEDICAID

Introduction

Medicaid is a medical assistance program, jointly funded by the federal, state, and county governments, which pays for health care for the poor and disabled. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for administering the Florida Medicaid Program. Statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The state budget for the Medicaid program for the current fiscal year is $8.3 billion and the program expects to serve 1.6 million clients this year.

Summary of Legislative Action Taken

Given the size of the Medicaid budget and the percentage of the state budget that Medicaid represents, the Legislature has been forced over the past several years to achieve fairly substantial Medicaid cost savings. Medicaid cost containment initiatives have primarily focused on three fronts: disease management; fraud and abuse; and prescribed drugs.

Disease Management

Beginning in 1997, the Legislature directed AHCA to establish disease management programs under the Medicaid program.

Fraud and Abuse Initiatives

The Legislature, the Attorney General's Office (specifically the Medicaid Fraud Control Unit), the Agency for Health Care Administration, the Office of Statewide Prosecutor, and the federal government have taken numerous steps over the past several years to combat fraud and abuse within the Florida Medicaid program. Past initiatives have included: claims payment analyses and controls; provider surety bonds and financial background checks; on-site provider visits; Level I and Level II criminal background checks; additional Medicaid Management Information System edits; and improved interagency coordination. More recent initiatives include: pharmacy audits, including on-site audits and audits specific to overpayments; an explanation of medical benefits mailing to some recipients; pharmacy lock-in, whereby a federal waiver has been obtained to permit the state to lock-in an abusive Medicaid recipient to a single pharmacy; recipient fingerprinting demonstration project at approximately 200 pharmacies to ensure that only the eligible recipient or an authorized representative is picking up prescribed drugs; enhanced claims analysis and automated fraud and abuse detection capabilities; additional pharmacy fraud and abuse controls, including surety bonds and on-site inspections prior to entering provider agreements; fraud detection system enhancements to identify patterns of fraud; and Physician Practice Pattern review, including drug usage evaluation, prescribing profiles, physician education, and outcomes analysis. Medicaid fraud issues adopted by the 2000 Legislature addressed additional surety bond requirements based on volume of business for certain Medicaid providers, additional authority for AHCA to deny Medicaid provider applications, and easier access to otherwise confidential patient information by the Attorney General's Medicaid Fraud Control Unit.

Prescribed Drug Initiatives

A more recent concern with the Medicaid budget has been the continued spiraling cost of the prescribed drug program. The 1999 Legislature established the Medicaid Formulary Study Panel by budget proviso to prepare recommendations on the advisability, feasibility, and cost-effectiveness of implementing an appropriate formulary for the Medicaid prescribed drug program. The following information was included in the panel's findings: "Since the mid-1990s the rate of increase in overall Medicaid expenditures has not exceeded 6 percent per year. However, the rate of increase for prescribed drugs has continued to grow at double-digit levels. In FY 1999-00 the rate of increase for the entire Medicaid program will be 6.0 percent compared to 16.9 percent for prescribed medicines. Some factors that contribute to increasing [prescribed drug] costs include direct marketing to consumers, increased marketing to providers, new and more expensive drug therapies for chronic illnesses, higher ingredient costs, multiple drug therapies, an aging population, recognition of new diseases, new uses of existing drugs, and changes in patient demographics." The panel supported maintaining an open formulary for Medicaid prescribed medicines and enhancing disease management initiatives to control prescription drug expenditures. The 2000 Legislature imposed prescribed drug reductions in Medicaid totaling $240.6 million.

Implementation

Disease management programs initially targeted were those specific to Medicaid recipients with a diagnosis of diabetes, hemophilia, asthma, and HIV/AIDS. In 1998, the Legislature added end stage renal disease, congestive heart failure, cancer, sickle cell anemia, and hypertension to the targeted disease list. In 1999, legislation was adopted to permit implementation of disease management programs for any condition. Through FY 1999-2000, the Medicaid budget had been reduced by $42 million in anticipation of savings resulting from implementation of the disease management initiative.

Through FY 1999-2000, budget reductions of $75 million had been made in expectation of savings from the various fraud and abuse activities and the Practice Pattern Review program.

Medicaid uses an open drug formulary, where recipients may obtain most prescription drugs without restriction. Adult recipients are limited to six prescriptions per month, but additional prescriptions are readily obtained if medically necessary. Many utilization limits are in place to prevent overuse or misuse, but most brand and generic drugs are available within their medically-accepted standards. Prescribed drug cost containment efforts in FY 2000-2001 include specific reductions resulting from: ingredient costs; a limit of four brand name prescription drugs per month (with exceptions and exclusions); a secure prescription program; a generic drug rebate program; pharmacy network controls; drug plan management program; a voluntary preferred drug list; and drug therapy limits.

Results and Impact

While the initiatives highlighted above have been a primary focus of cost containment, the Legislature has imposed a number of policy and funding reforms designed to achieve Medicaid budget reductions. Over the course of the last six fiscal years, a total of just over $1 billion has been projected for reduction from the Medicaid budget as a result of these specific initiatives.

LONG-TERM CARE

Introduction

Long-term care includes health-related services provided to elderly and disabled persons, and is frequently organized around the location in which it is delivered, i.e., nursing homes, assisted living facilities (ALF), intermediate care facilities for persons with developmental disabilities (ICFDD), mental health clinics, state institutions, and in homes. Services related to long-term care that are not location specific include home health, prescribed drugs, assistive technology, and personal care. Medicaid pays the majority of long-term care expenses. In Florida, two-thirds of all nursing home beds are paid for by Medicaid. Nursing home payments comprise 19.1 percent of the total Medicaid budget.

Elderly and disabled persons are about 20 percent of the Medicaid population. Their needs, however, account for almost 80 percent of the Medicaid budget. To manage these costs, Florida has primarily focused on controlling the growth and utilization of nursing homes.

The Committee on Elder Affairs and Long-Term Care has focused attention on nursing home quality of care for the past four years. Consumer advocates have raised a litany of complaints about patient abuse and neglect, theft of property, "patient dumping", and other problems. Litigation against nursing homes has increased significantly over the last few years. In 1998, the committee assembled a broad-based workgroup on nursing home quality improvement to recommend solutions. The 1999 Legislature enacted major reforms as a result of that study.

Summary of Legislative Action Taken

Chapter 99-394, Laws of Florida, addressed the most critical areas identified by the workgroup as related to quality of care: patient protection; financial stability; staffing; strong regulatory enforcement; and the availability of consumer information. Inadequate staffing in nursing homes was the most frequently cited problem during committee proceedings.

An early warning system was created, directing the Agency for Health Care Administration (AHCA) to track incident and trend data to identify and intervene when nursing homes decline or become financially unstable. Specialized nurses to work as "Quality of Care Monitors" were approved for each AHCA area office. Local Ombudsman Councils were directed to review patient transfer and discharge orders to prevent unfair and inappropriate movement of residents.

A study of issues related to training and availability of certified nursing assistants (CNAs) was prescribed. An appropriation of $32 million was provided to allow Medicaid to reimburse facilities for costs incurred to hire or retain direct care staff. AHCA was directed to measure customer satisfaction in nursing homes. That data and other specified information was to be provided to the public in booklets and on the Internet to assist consumers and their families in choosing a nursing facility. The Panel on Excellence in Long-Term Care was established to implement the "Gold Seal Program" to recognize outstanding performance by nursing homes.

To improve enforcement, fines for serious violations were substantially increased. AHCA was given the authority to compel facilities providing poor patient care related to inadequate staffing to hire more staff immediately. A Panel on Medicaid Reimbursement was established to study funding of nursing home care.

Implementation

The Quality of Care Monitors were hired, trained, and in the field by August 1999. The agency has developed a complex early warning system that includes evaluation of the financial well-being of each nursing home's corporation. AHCA also maintains detailed maps which precisely locate each licensed facility and those facilities near enough to act as an emergency placement for residents in case of an emergency shut down of the facility. In addition, the Department of Elder Affairs has completed a study of CNAs.

The agency has not been able to execute a contract for a vendor to conduct the satisfaction surveys. However, revisions made to the statute by the 2000 Legislature should provide the agency with sufficient flexibility to accomplish this before January 2001. The other required information has been published on the Internet and in booklet form for the public. The agency

promulgated a revised administrative rule to implement the revised fines and the authority to require facilities to add additional direct care staff immediately.

The Panel on Excellence in Long-Term Care has met four times since January 2000. The Panel on Medicaid Reimbursement issued an interim report in January 2000 and will submit a final report in December 2000.

Results and Impact

The industry has responded favorably to the assistance and oversight provided by the Quality of Care Monitors. To improve staffing, 600 of 650 Medicaid-participating nursing facilities have elected to participate in the reimbursement of additional costs associated with hiring and retaining direct care staff.

The 2000 Legislature created a Task Force on Long-Term Care to study and make recommendations about a number of critical issues. Included among these are alternatives to nursing home care, cost of various housing and care environments, the financial stability of nursing facilities, quality of care, effects of litigation, nursing home liability, and the cost and availability of insurance.

TOBACCO ENDOWMENT

Introduction

The State of Florida commenced a legal action against various tobacco manufacturers and other defendants in February 1995, asserting various claims for monetary and injunctive relief on behalf of the state. On August 25, 1997, Florida entered into a settlement agreement with several of the tobacco companies which called for approximately $11.2 billion to be received by the state over a 25-year period for reimbursement of Medicaid expenses, punitive damages, fraud, and RICO.

Summary of Legislative Action Taken

In 1999, to provide a mechanism for generating a recurring revenue stream from the non-recurring portions of the settlement receipts and to maximize the rate of return earned by the state, the Legislature created a new trust fund--the Lawton Chiles Endowment Fund (Endowment)--to be administered by the State Board of Administration (s. 215.5601, F.S.) The Endowment serves as a clearing trust fund and is funded by settlement moneys received from the tobacco industry. These moneys are to support increases in clients served or in costs in health and human services program areas.

The 2000 Legislature expanded legislative intent to provide a perpetual source of funding for health and human services initiatives for children and elders and for biomedical research programs. Two million dollars in nonrecurring funds were appropriated for the Biomedical Research Program, providing a dedicated funding stream for research of cancer, heart disease, stroke, pulmonary, and other diseases – all connected to tobacco consumption.

Implementation

For FY 2000-2001, funds in the Lawton Chiles Endowment Fund are to be distributed based on legislative appropriations. For FY 2001-2002 and beyond, funds are to be distributed as follows: (1) 50 percent to the Department of Children and Family Services (DCF) to be used for children's services; (2) 33.5 percent to the Department of Health (DOH) to be used for the biomedical research initiatives established in s. 215.5602, F.S.; (3) the remaining funds to the Department of Elder Affairs (DOEA) for elder services.

The Secretaries of the Department of Health, the Department of Children and Family Services, the Department of Elder Affairs, and the Agency for Health Care Administration are to develop a list of the top five funding priorities for children's and elder services eligible for funding from the Endowment. These lists are to be developed no later than October 1 of each year, and recommendations made available no later than November 15 of each year to the advisory councils for children's and elder services for evaluation and ranking for legislative consideration. Recommendations due to the Legislature by February 1 of each year are to include recommendations on funding levels for the ranked programs.

Results and Impact

Over 4 years, beginning with fiscal year 1999-2000, a total of $1.7 billion will be deposited into the Endowment from the Department of Banking and Finance Tobacco Settlement Clearing Trust Fund (s. 17.41, F.S.). In fiscal year 1999-2000, the amount deposited is $1.1 billion, with $200 million being deposited in each of the next 3 years. The State Board of Administration invests the Endowment funds, in accordance with an approved investment plan, as an annuity to protect the real value of the Endowment principal and to provide a predictable source of non-recurring revenue for Florida's children and elderly and for research into tobacco-related diseases.

WELFARE

Introduction

Aid to Families with Dependent Children (AFDC) (originally called Aid to Dependent Children) was created during the Depression as part of the Social Security Act of 1935. The program was administered by individual states, but jointly funded by both the federal and state governments. To qualify for AFDC, a child must be deprived of parental care and support due to the death, incapacity, continued absence from the home, or, in some states, unemployment of a parent. In 1992, the AFDC caseload was 252,276 families or 684,088 individuals. A sizeable percentage of the welfare population, in the range or 20 to 30 percent, was on welfare for substantial periods of time. Many of these families had cross-generational welfare dependency.

Summary of Legislative Action Taken

Largely in response to public demand for reform of the welfare system, in 1987 the Florida Legislature enacted the Florida Employment Opportunity Act, known as Project Independence -

the first attempt to move AFDC from a cash assistance program to a program that provided education and training to end the welfare dependency cycle.

In 1992, the Florida Legislature responded to continuing public dissatisfaction with welfare policy by passing the Family Transition Program (FTP), which reflected greater emphasis on work and training. Although limited to demonstration projects in two counties, FTP put Florida at the forefront of national welfare reform efforts - in particular, with its introduction of an innovative, new element to the work or learn for benefits approach - time limits on program benefits (AFDC grants) and other support services of 24 months for applicants and 36 months for recipients.

A new federal law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) repealed the 61-year-old entitlement, the AFDC program, and replaced it with a flat or capped block grant to states giving them primary control over eligibility and benefits. The law created the Temporary Assistance for Needy Families (TANF) Funds. TANF is a block grant that replaces the Aid to Families with Dependent Children (AFDC) welfare program.

Implementation

In 1996, the Legislature created the Work and Gain Economic Self-Sufficiency (WAGES) Program to take advantage of flexibility provided by the new federal law. Most Florida recipients are subject to a 24-month time limit on cash assistance out of any consecutive 60-month period. The more difficult participants to serve, those who have education deficits or health or other problems, are subject to a 36-month time limit on cash assistance out of any consecutive 72-month period. All recipients are limited to receiving benefits for a total of 48 months during their lifetime.

With the Workforce Innovation Act of 2000, the Legislature consolidated the many federal and state job training, employment support, and welfare transition programs implemented over the years to improve workforce development. The programs were removed from the Department of Labor and Employment Security and the Department of Children and Families and moved to a new Agency for Workforce Innovation under the leadership of a public-private board, Workforce Florida, Inc.

Results and Impacts

Florida has made great strides in removing barriers to employment and reducing reliance on welfare. Since October 1996 when the WAGES program began, the total number of families receiving cash assistance each month has declined 67 percent from 200,292 to 64,829 in June 2000. Welfare reform has not yet been tested by an economic downturn in which the low wage service jobs of the tourism industry in Florida may be vulnerable. To ensure long-term success, welfare reform and employment programs need to continue to improve their effectiveness and accountability. Welfare transition information systems and contract management need to be improved to ensure contracted services provide participants with long-term economic independence so they can avoid a return to cash assistance.

HEALTH CARE AND WELFARE
APPENDICES

Managed Care Reform Legislative Highlights
1996 - 2000

1996

Medicaid Managed Care and Emergency Care Access (CS/CS/SB 886; Ch. 96-199, Laws of Florida). Focused on emergency care issues relating to managed care organizations, and quality of care and enrollment standards relating to Medicaid health maintenance organizations (HMOs).

1997

Managed Health Care Entities (CS/CS/HBs 297 & 325; Ch. 97-159, Laws of Florida). Specified procedures, requirements and time frames for addressing subscriber grievances.

Managed Care/Direct Access to Dermatologists (SB 244; Ch. 97-171, Laws of Florida). Provided direct access to dermatologists who are under contract with HMOs and exclusive provider organizations without the need for a subscriber/member to go through a primary care physician.

1998

Managed Care/Subscriber Grievances (CS/SB 162; Ch. 98-10, Laws of Florida). Revised criteria and procedures for review of grievances against managed care entities by the Statewide Provider and Subscriber Assistance Panel.

Managed Care/Claims (SB 1584; Ch. 98-79, Laws of Florida). Provided additional procedures and timeframes for reimbursement by HMOs to providers for services rendered.

Health Insurance (CS/CS/SB 1800; Ch. 98-159, Laws of Florida). Increased HMO surplus and solvency requirements.

1999

HMO Contracts (CS/SB 232; Ch. 99-264, Laws of Florida). Provided due process protections regarding communication between providers and patients, and delineated termination rights for providers and patients.

Managed Care (CS/HB 1927 & 961; Ch. 99-393, Laws of Florida). Required publication of HMO report cards and authorized HMOs to offer an optional "point-of-service" benefit plan rider under specified circumstances.

Health Care (HB 2231; Ch. 99-356, Laws of Florida). Required exclusive provider organizations (EPOs) and HMOs to allow direct access for their female subscribers to a contracted obstetrician/gynecologist for one annual visit and medically necessary follow-up care detected during the annual visit, and authorized EPOs and HMOs to require such an

obstetrician/gynecologist treating a covered patient to coordinate the medical care provided through the patient's primary care physician, if applicable.

Health Provider Contracts (CS/SB 2554; Ch. 99-275, Laws of Florida). Clarified payment arrangements involving fiscal intermediaries, required advance notice of any increase in copayments, clarified circumstances under which coverage cancellation for nonpayment of premium must occur, and addressed provider exclusive contract issues.

2000

Patient Protection Act of 2000 (CS/HB 2339; Ch. 2000-256, Laws of Florida). Provided summary of patient protections relating to managed care, ensured continuity of care for hospital patients, required adverse determinations to be made by physicians only, and increased consumer awareness regarding grievance procedures and dispute resolutions.

Prompt Payment of Claims (CS/CS/SB 1508 & CS/SB 706; Ch. 2000-252, Laws of Florida). Clarified and strengthened requirements for claim submissions and reimbursements between providers and managed care organizations.

MEDICAID COST CONTAINMENT INITIATIVES (IN MILLIONS)

Fiscal Year 1994-1995:

New fiscal agent contract	$10.6
Childhood immunizations—OBRA '93	$3.5
Developmentally disabled bed and waiver revisions	$0.9
Reinstatement of pharmacy copayments	$6.0
Total for fiscal year 1994-95	$21.0

Fiscal Year 1995-1996:

Start prospective drug utilization review system	$7.6
Increase or establish copayments	$5.1
Reform community mental health	$26.0
Reform transportation	$17.0
Reform case management	$7.6
HMO age band and regional rates	$74.3
Accelerate managed care enrollment	$19.1
3% reduction for non-institutional services excluding physician services	$9.1
Reduce pharmacy cost increase	$32.7
Hospital reimbursement reforms	$30.0
Eliminate pressure ulcer pilot	$6.1
Nursing home incentive payments	$13.6
Total for fiscal year 1995-96	$248.2

Fiscal Year 1996-1997:

Intermediate Care Facility/Development Disabled (ICF/DD)	$34.3
Community mental health	$21.4
Hospital inpatient psychiatric	$12.3
HMO and prepaid health plans	$24.7
Pharmacy	$23.1
Transportation	$22.9
County billing/HMO inpatient days	$18.5
Nursing home reforms	$17.0
Hospital outpatient	$13.7
Home health care	$13.4
Provider enrollment reforms	$11.0
Estate recovery	$7.0
Medicaid administrative reform	$2.0
Total for fiscal year 1996-97	$221.3

Fiscal Year 1997-1998

Expand nursing home diversion waiver	$12.4
Third-party liability enhanced functions	$10.0
Variable pharmacy dispensing fee	$6.2
Mental health provider credentialing	$5.0

Disease management initiatives	$4.2
Competitive bidding of selected services	$3.9
Contracting with provider service networks and local governments	$3.3
Total for fiscal year 1997-98	$45.0

Fiscal Year 1998-1999

Intensified third party liability	$12.4
Eliminate adult cardiac transplant program	$1.6
Recalculation of drug rebate program	$11.3
Expanded fraud and abuse recoupment	$9.1
Disease management (current)	$24.7
Disease management (new)	$14.7
Modify methodology for Medicaid cross-over claims	$63.6
Total for fiscal year 1998-99	$137.4

Fiscal Year 1999-2000

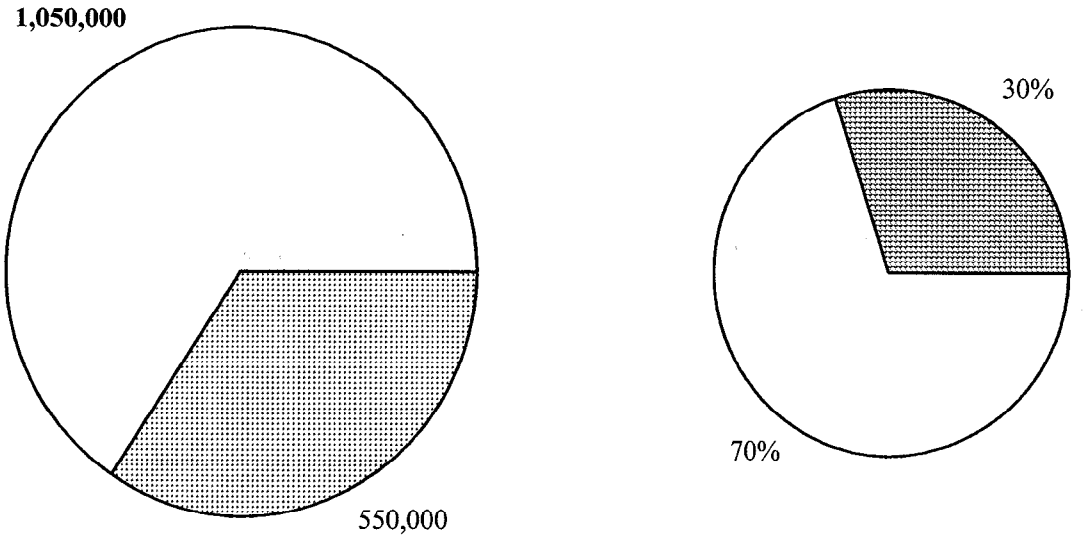
Enroll pregnant women in managed care programs	$18.2
Prescribed drug fraud and abuse initiatives	$34.5
Prescribed drug provider profiling and medical utilization review	$40.7
Total for fiscal year 1999-00	$93.4

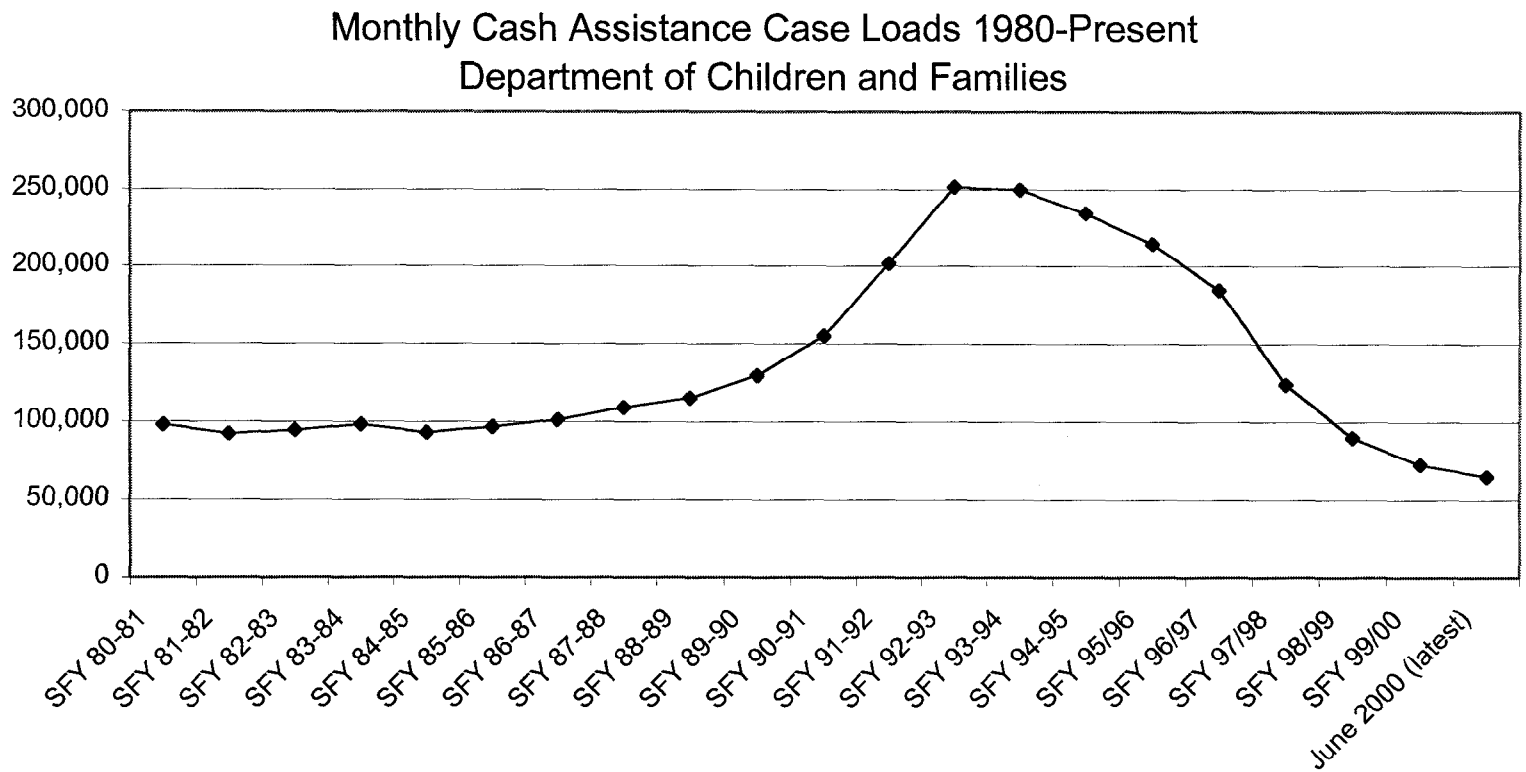
Fiscal Year 2000-2001

Ingredient cost adjustments/prescribed drugs	$24.2
Drug benefit management program	$41.0
Pharmacy network controls	$22.6
Secure prescription pads	$18.0
Generic drug rebates	$3.0
Monthly limit on recipient drugs	$70.0
Improve case management of MediPass recipients	$46.1
Improve disease management efficiencies	$23.0
Voluntary preferred drug list	$25.0
Drug therapy limits	$10.0
Total for fiscal year 2000-01	$282.9

Grand Total $1,068.3

Comparison of Number of Persons by Category of Eligibility with
Percent Expenditures by Category of Eligibility




Monthly Cash Assistance Case Loads 1980-Present
Department of Children and Families
300,000
250,000
200,000
150,000
100,000
50,000
0
SFY 80-81
SFY 81-82
SFY 82-83
SFY 83-84
SFY 84-85
SFY 85-86
SFY 86-87
SFY 87-88
SFY 88-89
SFY 89-90
SFY 90-91
SFY 91-92
SFY 92-93
SFY 93-94
SFY 94-95
SFY 95/96
SFY 96/97
SFY 97/98
SFY 98/99
SFY 99/00
June 2000 (latest)